Section 5
Attachments

Attachment A

Competitive POS Application Checklist

Proposal Application Checklist

Applicant: _____ RFP No.: HTH 420-11-05

The applicant's proposal must contain the following components in the order shown below. This checklist must be signed, dated and returned to the state purchasing agency as part of the Proposal Application. *SPO-H forms are located on the web at http://www.spo.hawaii.gov Click *Procurement of Health and Human Services* and *For Private Providers.**

Item	Reference in RFP	Format/Instructions Provided	Required by Purchasing Agency	Completed by Applicant
General:				
Proposal Application Identification Form (SPO-H-200)	Section 1, RFP	SPO Website*	**X**	
Proposal Application Checklist	Section 1, RFP	Attachment A	**X**	
Table of Contents	Section 5, RFP	Section 5, RFP	**X**	
Proposal Application (SPO-H-200A)	Section 3, RFP	SPO Website*	**X**	
Registration Form (SPO-H-100A)	Section 1, RFP	SPO Website*	**(Required if not Registered)**	
Tax Clearance Certificate (Form A-6)	Section 1, RFP	Dept. of Taxation Website (Link on SPO website)*		
Cost Proposal (Budget)				
SPO-H-205	Section 3, RFP	SPO Website*	**X**	
SPO-H-205A	Section 3, RFP	SPO Website* Special Instructions is applicable, Section 5	**X**	
SPO-H-205B	Section 3, RFP,	SPO Website* Special Instructions, Section 5		
SPO-H-206A	Section 3, RFP	SPO Website*	**X**	
SPO-H-206B	Section 3, RFP	SPO Website*	**X**	
SPO-H-206C	Section 3, RFP	SPO Website*	**X**	
SPO-H-206D	Section 3, RFP	SPO Website*	**X**	
SPO-H-206E	Section 3, RFP	SPO Website*	**X**	
SPO-H-206F	Section 3, RFP	SPO Website*	**X**	
SPO-H-206G	Section 3, RFP	SPO Website*		
SPO-H-206H	Section 3, RFP	SPO Website*	**X**	
SPO-H-206I	Section 3, RFP	SPO Website*	**X**	
SPO-H-206J	Section 3, RFP	SPO Website*	**X**	
Certifications:				
Federal Certifications		Section 5, RFP	**X**	
Debarment & Suspension		Section 5, RFP	**X**	
Drug Free Workplace		Section 5, RFP	**X**	
Lobbying		Section 5, RFP	**X**	
Program Fraud Civil Remedies Act		Section 5, RFP	**X**	
Environmental Tobacco Smoke		Section 5, RFP	**X**	
Program Specific Requirements:				

_____ _____

Authorized Signature Date

Attachment B

Sample Table of Contents for the POS Proposal Application

Proposal Application
Table of Contents

Attachment C

Draft Special Conditions

SPECIAL CONDITIONS

1. Time of Performance. The PROVIDER shall provide the services required under this Agreement from _____, to and including _____, unless this Agreement is extended or sooner terminated as hereinafter provided.

2. Option to Extend Agreement. Unless terminated, this Agreement may be extended by the STATE for specified periods of time not to exceed three (3) years or for not more than three (3) additional twelve (12) month periods, without resolicitation, upon mutual agreement and the execution of a supplemental agreement. This Agreement may be extended provided that the Agreement price shall remain the same or is adjusted per the Agreement Price Adjustment provision stated herein. The STATE may terminate the extended agreement at any time in accordance with General Conditions no. 4.

3. Agreement Price Adjustment. The Agreement price may be adjusted prior to the beginning of each extension period and shall be subject to the availability of state funds.

4. Audit Requirement. The PROVIDER shall conduct a financial and compliance audit in accordance with the guidelines identified in Exhibit _____ attached hereto and made a part hereof. Failure to comply with the provisions of this paragraph may result in the withholding of payments to the PROVIDER.

5. The PROVIDER shall have bylaws or policies that describe the manner in which business is conducted and policies that relate to nepotism and management of potential conflicts of interest.

Attachment D

Consumer Rights

DRAFT XX/XX/XX

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL AMHD Administration SUBJECT: Consumer Rights REFERENCE:	**Number: 60.X00X.NEW** Effective Date: XX/XX/XX History: New Page: 1 of 7 Recommended: _____ Title: Medical Director, AMHD APPROVED: _____ Title: Chief, AMHD_____

PURPOSE

To ensure that specified rights of each consumer are protected.

POLICY

Each provider shall have a statement designed to protect consumer's rights and comply with requirements of the Americans with Disabilities Act. The statement shall be:

a. Consistent with Federal and State laws and regulations;

b. Posted in strategic and conspicuous areas to maximize consumer, family and staff awareness;

c. Signed and dated by the consumer prior to treatment; and

d. Maintained in the treatment records of consumers.

PROCEDURE

A. The statement given to consumers must include at the minimum the following language:

1. You have rights no matter what your situation is. Adult Mental Health Division (AMHD) and all its providers will uphold these rights. You have these rights regardless of your:

    - Age
    - Race
    - Sex
    - Religion
    - Culture
    - Amount of education
    - Lifestyle
    - Sexual orientation
    - National origin
    - Ability to communicate
    - Language spoken
    - Source of payment for services
    - Physical or mental disability

2. You have the right to be treated with respect and dignity, and to have your right to privacy respected.

3. You have the right to know about the AMHD, the services you can receive, who will provide the services, and their training and experience.

4. You have the right to have as much information about your treatment and service choices as you need so you can give an informed consent or refuse treatment. This information must be told to you in a way you can understand. Except in cases of emergency services, this information shall include a description of the treatment, medical risks involved, any alternate course of treatment or no treatment and the risks involved in each.

5. You have a right to information about your medications; what they are, how to take them, and possible side effects.

6. You have a right to be informed of continuing care following discharge from the hospital or outpatient services.

7. You have a right to look at and get an explanation of any bills for non-covered services, regardless of who pays.

8. You have a right to receive emergency services when you, as a prudent layperson, acting reasonably, would believe that an emergency medical condition existed. Payment for emergency services will not be denied in cases when you go for emergency services.

9. You have a right to receive emergency services when traveling outside the State of Hawaii when something unusual prevents you from getting care from an AMHD provider.

10. You have a right to usually have the same provider when you get services.

11. You have a right to an honest discussion with your providers of the options for your treatment, regardless of cost and benefit coverage.

12. You have a right to be advised if a provider wants to include you in experimental care or treatment. You have the right to refuse to be included in such research projects.

13. You have a right to complete an advance directive, living will, psychiatric advance directive, medical durable powers of attorney or other directive to your providers.

14. You have a right to have any person who has legal responsibility make decisions for you regarding your mental health care. Any person with legal responsibility to make health care decisions for you will have the same rights as you would.

15. You have the right to know all your rights and responsibilities.

16. You have the right to get help from AMHD in understanding your services.

17. You are free to use your rights. Your services will not be changed and you will not be treated differently if you use your rights.

18. You have the right to receive information and services in a timely way.

19. You have the right to be a part of all choices about your treatment. You have the right to have a copy of your written Individual Service Plan.

20. You have the right to disagree with your treatment or to ask for changes in your Individual Service Plan.

21. You have the right to ask for a different provider or case manager. If you want a different provider or case manager, we will work with you to find another one in the AMHD network.

22. You have the right to refuse treatment to the extent allowed by the law. You are responsible for your actions if you refuse treatment or if you do not follow your providers' advice.

23. You have the right to get services in a way that respects your culture and what you believe in.

24. You have the right to an interpreter, if needed, to help you speak to AMHD or your providers. You have the right to have an interpreter in the room when your provider sees you.

25. You have the right to ask us to send you mail and call you at the address or telephone number of your choice, in order to protect your privacy. If we cannot honor your request, we will let you know why.

26. You have a right to a second opinion when deciding on treatment.

27. You have the right to expect that your information will be kept private according to the Privacy law.

28. You have the right to complain about your services and to expect that no one will try to get back at you. If you complain, your services will not stop unless you want them to.

29. You have the right to be free from being restrained or secluded unless a doctor or psychologist approves, and then only to protect you or others from harm. Seclusion and restraints can never be used to punish you or keep you quiet. They can never be used to make you do something you don't want to do. They can never be used to get back at you for something you have done.

If you have any questions or concerns about these rights, you can speak to the Rights Advisor at your Community Mental Health Center or call the AMHD Consumer Advisor at (808) 586-4688.

B. Each consumer must be provided an orientation to the program at a level educationally appropriate for the consumer, communicated in either the consumer's native language or sign language, as is appropriate for the individual. Documentation of the orientation must be kept in the consumer's treatment record and signed and dated by the consumer. If a consumer who received the orientation refuses to sign the form acknowledging that he/she received information regarding his/her rights, the staff shall document on the form that the consumer refuses to sign and the date that the information was provided to the consumer. At a minimum such orientation must include:

1. An explanation of the:

    a) Rights and responsibilities of the consumer,

    b) Grievance and appeal procedures

    c) Ways in which input is given regarding:

        - the quality of care
        - achievement of outcomes
        - satisfaction of the consumer

2. An explanation of the organization's:

    a) Services and activities

    b) Expectations

    c) Hours of operation

    d) Access to after-hour services

    e) Code of ethics

    f) Confidentiality policy

g) Requirements for follow-up for the mandated consumer served, regardless of his or her discharge outcome

3. An explanation of any and all financial obligations, fees, and financial arrangements for services provided by the organization

4. Familiarization with the premises, including emergency exits and/or shelters, fire suppression equipment, and first aid kits

5. The program's policies regarding:

   a) the use of seclusion or restraint

   b) Smoking

   c) Illicit or licit drugs brought into the program

   d) Weapons brought into the program

6. Identification of the person responsible for case management

7. A copy of the program rules to the consumer, that identifies the following:

   a) Any restrictions the program may place on the consumer

   b) Events, behaviors, or attitudes that may lead to the loss of rights or privileges for the consumer

   c) Means by which the consumer may regain rights or privileges that have been restricted

8. Education regarding advance directives, when legally applicable

9. Identification of the purpose and process of the assessment

10. A description of how the Individualized Service Plan (ISP) or other plan will be developed and the consumer's participation

11. Information regarding transition criteria and procedures

12. When applicable, an explanation of the organization's services and activities include:

    a) Expectations for consistent court appearances

    b) Identification of therapeutic interventions, including:

    - Sanctions
    - Interventions
    - Incentives
    - Administrative discharge criteria

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment E

Division P&P Regarding Consumer Grievances

Division P&P Regarding Consumer Appeals

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.X00X.NEW**
AMHD Administration	Effective Date: XX/XX/XX History: New
SUBJECT: Consumer Grievances	Page: 1 of 6
REFERENCE: Consumer Appeals, Consumer Rights, Consumer Handbook	Recommended: _____ Title: Medical Director, AMHD
	APPROVED: _____ Title: Chief, AMHD_____

PURPOSE

To outline the internal process and procedure for reviewing and resolving consumer grievances or any expressions of dissatisfaction.

POLICY

The grievance process is administered by Adult Mental Health Division's (AMHD) Office of Consumer Affairs.

A description of AMHD's grievance process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing a grievance.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or grievances not acted upon within prescribed timeframes.

- Appeal – A request for review of an action made by AMHD, as "action" is defined. Consumer Appeals are discussed in a separate policy and procedure.

- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.

- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as "action" is defined.

- Grievance Review – A review process for grievance resolutions. A consumer may request a "grievance review" by AMHD if they do not agree with a provider's resolution of a grievance.

- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD's or a provider's operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

PROCEDURE

1. Inquiry

    A. Consumers should call their Case Manager for any Inquiry or question regarding any aspect of AMHD or a provider's operations, activities, or behavior, or request to change to another provider.

    B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance or Appeal (see Grievance and Appeal process below).

2. Grievance

    A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:

- AMHD or provider's operations
- AMHD or provider's activities
- AMHD or provider's failure to respect the consumer's rights
- AMHD or provider's behavior
- Provider or AMHD employee is rude
- Provider quality of care
- AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.

B. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer, may file a grievance orally or in writing.

(1) For oral filing of grievance, the consumer may call the Office of Consumer Affairs and a Consumer Specialist will assist the consumer in writing the grievance by completing an AMHD Consumer Grievance Form (see Attachment A), however, any AMHD staff may assist the consumer and may complete the Grievance Form. The Consumer will be given an option to receive a copy of the written grievance. The form is forwarded to the individual responsible for tracking grievances within the Office of Consumer Affairs who is defined as the Grievance Coordinator.

(2) If a provider or an authorized representative on behalf of the consumer files the grievance orally, the consumer must give written authorization.

(3) The Grievance Coordinator directs the grievance to the appropriate individual within AMHD for investigation and resolution of the grievance. That individual forwards the written results of their investigation and resolution to the Grievance Coordinator for data entry and tracking.

(4) All written grievances should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Grievance Coordinator
P.O. Box 3378
Honolulu, Hawaii 96801-3378

(5) Within five (5) working days of the receipt date, the grievant will be informed by letter that the grievance has been received.

(6) Each grievance will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

(7) AMHD will render a resolution of the grievance within thirty (30) calendar days of the receipt date. If the thirtieth (30^{th}) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered the next working day. A letter of resolution will be mailed to the grievant and copies are sent to all parties whose interest has been affected by the decision. If the grievant has requested not to be identified, consumer identifying information will be left off other parties' letters.

(8) The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

C. The resolution letter includes and describes the following details:

- Nature of the grievance
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures.
- A statement that AMHD's resolution of the grievance is final, unless the consumer requests an appeal by contacting the Office of Consumer Affairs.

D. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests an extension or if additional information is needed. In this case, a letter will be sent to the grievant. The content of the notification will include the following details:

- Nature of the grievance
- Reason for the extension of the decision and how the extension is in the consumer's interest

3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. The appeal process is discussed in a separate policy and procedure.

4. Other Requirements

A. The AMHD Grievance Coordinator shall compile an aggregate quarterly grievance report and submit such report to the Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

The Aggregate Grievance Report shall at a minimum include the following elements:

(1) Number of grievances sorted by date, nature of the grievance, county, and provider of services, if applicable;

2) Status of Resolution and if resolved, result including feedback, and

3) Turn-around times.

B. An Aggregate Annual Grievances Report shall be prepared and presented to the Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis by county, and recommendations for improvement of clinical and service areas.

C. Privacy of the grievance records is maintained at all times, including the transmittal of medical records.

D. All grievances and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of grievance.

E. All grievances that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be collated by Performance Management and used in certification and contract activities.

ATTACHMENTS

Consumer Grievance Form

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment A

Consumer Grievance Form

Date Received: _____

Taken by: _____

Consumer Name: _____

AMHD ID#: _____

Mailing Address: _____

Island: _____

Telephone #: _____

Name of Grievant: _____

Relationship to Consumer: _____

Mailing Address: _____

Telephone Number: _____

Note: If a representative is filing an oral grievance on behalf of an adult consumer, please obtain a written authorization from the consumer through the Authorization To Disclose Protected Information form.

Type of Contact: □ Letter
□ Telephone
□ In Person
Consumer Request Copy of Grievance? Yes □ No □

Grievance Regarding:

□ Provider

Full Name: _____

□ AMHD

Date(s) Problem began: _____

Description of Grievance: _____
_____
_____
_____
_____
_____
_____
_____
_____

□ Reviewed written grievance with consumer verbally on: _____

For Grievance Coordinator Use Only: File#: _____
Sent copy of grievance to consumer on: ___/___/___
Sent acknowledgement letter on: ___/___/___
Sent to _____on: ____/_____/_____ New 12/03/03 hj

DRAFT XX/XX/XX

ADULT MENTAL HEALTH DIVISION

POLICY AND PROCEDURE MANUAL	**Number: 60.903 REV**
AMHD Administration	Effective Date: XX/XX/XX History: 5/03
SUBJECT: Consumer Appeals	Page: 1 of 9
REFERENCE: Consumer Grievances, Denial Letter, Consumer Handbook HRS 91	Recommended: _____ Title: Medical Director, AMHD
	APPROVED: _____ Title: Chief, AMHD_____

PURPOSE

To outline the process by which a consumer may appeal an action or decision made by Adult Mental Health Division (AMHD).

POLICY

The consumer appeals process is administered by the Office of Consumer Affairs.

A description of AMHD's appeals process is included in the Consumer Handbook, which is distributed to all consumers within ten (10) days of entry into the AMHD service system. There is no punitive or retaliatory action taken against a consumer, consumer advocate or provider, acting on behalf of the consumer, for filing an appeal.

DEFINITIONS

- Action – The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, unreasonable delays in services, or appeals not acted upon within prescribed timeframes.

- Appeal – A request for review of an action may by AMHD, as "action" is defined.

- Consumer – Anyone who is receiving services or potentially could be eligible to receive services.

- Grievance – An expression of dissatisfaction from a consumer or provider, or any authorized representative on behalf of the consumer about any matter other than an action, as "action" is defined.

- Grievance Review - A review process for grievance resolutions. A consumer may request a "grievance review" by AMHD if they do not agree with a provider's resolution of a grievance.

- Inquiry – A contact from a consumer, or on behalf of the consumer, that questions any aspect of AMHD's or a provider's operations, activities, or behavior, or to request change to another provider, and does not express dissatisfaction.

PROCEDURE

1. Inquiry

    A. Consumers should call their Case Manager for any Inquiry or question regarding any aspect of AMHD or a provider's operations, activities, or behavior, or request to change to another provider.

    B. If during the contact, the consumer expresses dissatisfaction of any kind, the Inquiry becomes an expression of dissatisfaction and becomes a Grievance (see Grievance and Appeal process below).

2. Grievance

    A. Consumers may file a grievance if they express any dissatisfaction in regards to the following:

        - AMHD or provider's operations
        - AMHD or provider's activities
        - AMHD or provider failure to respect the consumer's rights
        - AMHD or provider's behavior
        - Provider or AMHD employee is rude
        - Provider quality of care

- AMHD or provider's privacy practices – copies of these grievances are also forwarded to AMHD's Privacy Officer.

B. The grievance process is administered by the Office of Consumer Affairs as delineated in the Consumer Grievances Policy and Procedures.

3. Appeals

A. Consumers may file an appeal for the following actions or decisions made by AMHD:

- Prior authorization for a service is denied or limited
- The reduction, suspension, or termination of a previously authorized service
- The denial, in a whole or in part, of payment for a service
- The denial of eligibility
- Failure to provide services in a timely manner
- Unreasonable delays in services, or appeals not acted upon within prescribed timeframes
- Not satisfied with resolution of grievance

B. Assessment and Utilization Management shall notify consumers about their appeal rights and processes at the time of denial of eligibility or service request. Consumers shall have access to consumer advocacy and AMHD shall assure that any consumer who requests an advocate for this process shall be linked to this assistance.

C. A consumer, provider or a consumer's authorized representative, acting on behalf of the consumer with the consumer's written consent or if documentation is available to demonstrate the consumer is incapacitated, may file an appeal orally or in writing.

D. For oral filing of appeal, the consumer (or consumer's representative with the written consent of the consumer or if documentation is available to demonstrate the consumer is incapacitated), may call the Office of Consumer Affairs and must also submit a follow-up written appeal.

E. The designated case manager, or the designated crisis support manager, may appeal on behalf of the consumer without written consent if documentation is available to demonstrate the consumer is incapacitated. The case manager or crisis support manager shall provide specified clinical information to support the appeal request.

F. An AMHD Consumer Appeal Form (see Attachment A) may also be completed on behalf of the consumer or consumer's representative. In this case, the completed Consumer Appeal Form will be sent to the consumer or the consumer's authorized representative if a written authorization has been received for review and signature.

G. The consumer or the consumer's authorized representative must submit the follow-up written appeal or return the signed Consumer Appeal Form to the Office of Consumer Affairs which is designated as the Consumer Appeals Coordinator within one (1) week from the receipt date of the oral appeal. If the follow-up written appeal or the signed Consumer Appeal form is not received within the allotted timeframe, a follow-up call will be made to the consumer or the consumer's representative. If the consumer requests an extension for the filing deadline of the written appeal, AMHD will grant another one (1) week to submit the written appeal.

H. If a written follow-up is not received, the appeal will be closed after thirty (30) calendar days without further action or investigation. The consumer will receive written notification of this.

I. If a provider files a written appeal on behalf of a consumer, it will be initially designated as a Provider Complaint unless accompanied by the consumer's written consent. If the written appeal is filed with the consumer's written consent, AMHD will contact the provider to determine if consent was given. If the written consent is received, AMHD will transfer the Provider Complaint to a Consumer Appeal.

J. All written appeals should be submitted to:

Adult Mental Health Division
Office of Consumer Affairs
Consumer Appeal
P.O. Box 3378
Honolulu, Hawaii 96801-3378

4. First Level Appeal

   A. The appeal must be filed within thirty (30) days from the date of the initial action or decision made by AMHD. Exceptions to this deadline may be granted if details regarding extenuating circumstances are provided. At no time will an appeal be considered that is 180 days from the date of the initial action or decision made by AMHD.

   B. Within five (5) working days of receipt of the written appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.

   C. The consumer or authorized representative of the consumer may request to examine the consumer's case file, including medical records and any other documents considered during or before the appeal process by contacting the Consumer Appeals Coordinator in accordance with federal and state privacy regulations.

   D. All appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

   E. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal.

   F. The AMHD Medical Director shall review the denial and shall make a determination (overturning or ratifying the denial). The AMHD Medical Director has the option of obtaining a second physician opinion prior to rendering a decision about the appeal.

   G. AMHD will render a resolution of the appeal within thirty (30) calendar days of the receipt date except in the case of an expedited appeal. If the thirtieth (30^{th}) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the provider and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

H. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Process for a second level appeal if appeal denied.

I. AMHD may grant an extension of the resolution deadline of up to fourteen (14) calendar days if the consumer requests the extension or if additional information is needed. In this case, a letter will be sent to the consumer. The content of the notification will include the following details:

- Nature of the appeal
- Reason for the extension of the decision and how the extension is in the best interest of the consumer

5. Expedited Appeals

A. Any AMHD consumer (or provider acting on behalf of the consumer with the consumer's written authorization) may request an expedited appeal.

B. An expedited appeal may be authorized if the standard review time frame of AMHD's appeal process may:

- Seriously jeopardize the life or health of the consumer
- Seriously jeopardize the consumer's ability to access services with limited availability with a resulting loss of function

C. All expedited appeals will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory and contractual provisions, as well as AMHD's policies and procedures.

D. The AMHD Medical Director will review all expedited appeals.

E. A decision will be rendered within forty-eight (48) working hours of receipt of the request for an expedited appeal.

F. The decision will be phoned by the Consumer Appeals Coordinator to the consumer and provider.

G. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Process for a second level appeal if appeal denied

6. Second Level Appeal

A. The consumer or appealing party may proceed with a written second level appeal within thirty (30) calendar days from the date of the first level appeal determination letter.

B. The second level appeal letter along with any additional clinical information shall be sent to the AMHD Chief who shall obtain all relevant documentation from the AMHD UM Coordinator and the AMHD Medical Director. The second level appeal will be thoroughly investigated by gathering facts from all relevant parties and using the applicable statutory, regulatory, and contractual provisions, as well as AMHD's policies and procedures.

C. For appeals regarding reduction, suspension, or termination of a previously authorized service such care will be continued until resolution of the appeal by the AMHD Chief.

D. Expedited appeals which result in an expedited second level appeal shall be reviewed and a decision rendered within forty-eight (48) working hours of receipt of the request for an expedited second level appeal if the request has been designated as such. The decision shall be phoned by the Consumer Appeals Coordinator to the consumer and provider.

E. Within five (5) working days of receipt of the written non-expedited second level appeal, the consumer, provider, or the consumer's authorized representative will be informed by letter that the appeal has been received.

F. AMHD will render a resolution of the appeal for non-expedited appeals within thirty (30) calendar days of the receipt date except in the case of expedited appeal. If the thirtieth (30^{th}) day falls on a Saturday, Sunday, or State holiday, a resolution will be rendered by the next working day. A letter of resolution will be mailed to the consumer and copies are sent to all parties whose interest has been affected by the decision. The effective date of the decision will be the date of personal delivery, or if mailed, the postmarked date of the mailing.

G. The resolution letter includes and describes the following details:

- Nature of the appeal
- Issues involved
- Actions AMHD has taken or intends to take
- Reasons supporting AMHD's decision or action, including references to applicable statutes, rules, and procedures
- Statement concerning any other avenues of appeal, if any, available to the appellant.

H. Consumers or their legal representatives who wish to appeal further must follow the Department of Health administrative appeals process, HR91f, or pursue through the legal system.

7. Other Requirements

A. The AMHD Consumer Appeals Coordinator shall compile a quarterly aggregate appeal report and submit such report to the Quality Council in the required format no later than forty-five (45) days from the end of each quarter.

The aggregate Appeals Report shall include at a minimum include the following elements:

(1) Number of appeals sorted by date, nature of the appeal, county level of appeal, and provider of services, if applicable,

(2) Number of decisions upheld,

(3) Number of decisions overturned, and

(4) Turn-around times.

B. An aggregate Annual Appeals Report shall be prepared and presented to the Quality Council within sixty (60) days of the last quarter of the calendar year. The report shall contain an aggregate data report, analysis, and recommendations for improvement of clinical and service areas.

C. Privacy of the appeal records is maintained at all times, including the transmittal of medical records.

D. All appeals and related documentation are maintained in a secure, designated area and retained for a period of seven (7) years following the final decision, or closure of appeal.

E. All appeals that concern provider organization actions and are proven quality of care or non-compliance with AMHD contracts or policies and procedures will be collated by Performance Management and used in certification and contract activities.

ATTACHMENTS

Consumer Appeal Form

Date of Review:___/___/___; ___/___/___; ___/___/___; ___/___/__

Initials: [_____] [_____] [_____] [_____]

Attachment A

Consumer Appeal Form

Print Name of Consumer: _____

AMHD ID#: _____

Mailing Address: _____

Island: _____

Phone Number: _____

Signature of Consumer: _____ Date Signed: _____

Note to Consumer: By signing this form, you as a consumer are authorizing your provider or any representative (if there's any) to file this appeal on your behalf.

** Please fill out this section if a provider or a representative is filing the appeal on behalf of the consumer**

Print Name of Representative: _____

Relationship to Consumer: _____

Phone Number: _____

Mailing Address: _____

Signature of Representative: _____ Date Signed: _____

Description of Service: _____

Date(s) of Service: _____

Describe on the space below what you disagree with and why. Also include copies of any papers that have to do with the appeal.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(Write on back of this form if you need more space. Or write your appeal on a separate sheet and attach to this form)

<u>You must sign this form and send it back to us within one (1) week.</u> Please sent it to: Adult Mental Health Division, Attn. Consumer Appeals Coordinator, P.O. Box 3378, Honolulu, Hawaii 96801-3378. Or if you need help, call us at (808)586-4691 (Oahu)

Attachment F

QMHP AND SUPERVISION

Qualified Mental Health Professional (QMHP)

A Qualified Mental Health Professional ("QMHP") is defined as a Licensed Psychiatrist, Licensed Clinical Psychologist (Ph.D. or Psy.D.), Licensed Clinical Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), or Licensed Advanced Practice Registered Nurse (APRN) in behavioral health currently licensed in the State of Hawaii.

The QMHP shall oversee the development of each consumer's treatment plan to ensure it meets the requirements stated in the Community Plan 2003 and sign each treatment plan.

The QMHP shall serve as a consultant to the treatment team.

The QMHP shall serve as the LOCUS expert.

The QMHP shall provide oversight and training.

The QMHP shall review and sign each authorization request for clinical services prior to submittal to ensure that the services requested are medically necessary.

The QMHP shall provide clinical consultation and training to team leaders and/or direct care providers as needed.

Additionally, for Specialized Residential Treatment Programs, the QMHP shall provide day-to-day program planning, implementation, and monitoring.

Mental Health Professionals (MHP)

Except for Assertive Community Treatment ("ACT"), the team leader is not required to be a QMHP. Non-QMHP team leaders shall be clinically supervised by a QMHP.

Non-QMHP team leaders are defined as Mental Health Professionals ("MHP") and shall meet the following minimum requirements:

- Licensed Social Worker (LSW); or
- Master of Science in Nursing (MSN); or
- APRN in a non-behavioral health field; or
- Master's degree from accredited school in behavioral health field
    a) Counseling, or
    b) Human Development, or
    c) Marriage, or
    d) Psychology, or
    e) Psychosocial Rehabilitation, or
    f) Criminal Justice.
- Master's degree in health related field with two (2) years experience in behavioral health; or

- Licensed Registered Nurse with a Bachelors in Nursing and five (5) years experience in behavioral health

The MHP may supervise para-professional staff if the MHP is clinically supervised by a QMHP.

The MHP may function as the DIVISION Utilization Management Liaison.

Supervision:

Clinical supervision of all staff is ongoing and shall be sufficient to ensure quality services and improve staff clinical skills and is according to community standards, scope of license as applicable, and agency policies and procedures. Treatment team meetings are consumer focused whereas clinical supervision is staff focused. Therefore, treatment team meetings do not need to meet clinical supervision requirements.

One-on-one clinical supervision of MHP team leaders and direct care providers, if there is no MHP team leader, shall be performed by the QMHP at a minimum of once per month. If a MHP is the team leader, the MHP shall provide one-on-one monthly clinical supervision of non-MHP and non-QMHP staff.

The supervision shall be documented in writing, legible, signed and dated by the QMHP or MHP as directed by the provider agency's policies and procedures.

The DIVISION funded PROVIDER shall have policies and procedures to select and monitor the MHP team leaders if non-QMHP team leaders are used.

The QMHP and non-QMHP staff do not have to work in the same physical setting but shall have routine meetings as defined in the PROVIDER's policies and procedures.

Attachment G

Crisis Triage Rating Scale

CTRS DEFINITIONS

CRISIS	DEFINITION	GOAL	TYPES OF SERVICE
Low End Crisis (13-15)	Impaired life skills, loneliness, lacks support, non-acute personal crisis	Promotion, Prevention, Early Intervention	Support-service providers, peers, family, significant other. Distress Line. Referrals-AMHS-AFSS, Other.
Medium Intensity Crisis (10-12)	Psychosocial crisis. Early decompensation (not serious enough to warrant hospitalization)	Early Intervention. Restabilization.	Distress Line, De-escalation. Contracting Short-term. Follow-up, Referrals (urgent appointments-AMHS, Outreach). Possible Short-term stabilization.
High Intensity (1-9)	Acute decompensation, Child at Risk? Psychotic Episode, Homicidal, Suicidal	Control and de-escalation, Stabilization, Treatment	Warrant/police authority. Hospital emergency- acute hospital treatment. Crisis psychiatric assess to facility, other hospital admission procedures, Contracting. Referral for Follow-up.

CRISIS TRIAGE RATING SCALE

Intructions: Score 1 to 5 in each category using descriptive statements as guidelines.

CATEGORY	SCORE
A. Dangerousness 1. Expresses or hallucinates suicidal/homicidal ideas or has made serious attempt in present illness. Unpredictably impulsive/violent. 2. Same as 1, but ideas or behavior are to some degree ego-dystonic or history of violent or impulsive behavior but no current signs. 3. Expresses suicidal/homicidal ideas with ambivalence or has made only ineffective gestures. Questionable impulse control. 4. Some suicidal/homicidal ideation or behavior, or history of same, but clearly wishes and is able to control behavior. 5. No suicidal/homicidal ideation or behavior. No history of violent/impulsive behavior. Score for Dangerousness	
B. Support System 1. No family, friends, or others. Agencies cannot provide immediate support needed. 2. Some support might be mobilized but its effectiveness will be limited. 3. Support system potentially available but significant difficulties exist in mobilizing it. 4. Interested family, friends, or others but some question exists of ability or willingness to help. 5. Interested family, friends, or others able and willing to provide support needed. Score for Support System	
C. Ability to Cooperate 1. Unable to cooperate or actively refuses. 2. Shows little interest in or comprehension of efforts to be made in his behalf. 3. Passively accepts intervention maneuvers. 4. Wants to get help but is ambivalent or motivation is not strong. 5. Actively seeks outpatient treatment, willing and able to cooperate. Score for Ability to Cooperate	
TOTAL SCORE	
DISPOSITION: ☐ Referred for inpatient intervention ☐ Outpatient crisis intervention	

0022-3018/84/1727-0424$02.00/0
THE JOURNAL OF NERVOUS AND MENTAL DISEASE
Vol. 172, No. 7
Printed in U.S.A.

A Crisis Triage Rating Scale

Brief Dispositional Assessment of Patients at Risk for Hospitalization

HERBERT BENGELSDORF, M.D., LAWRENCE E. LEVY, M.D., ROSA LEE EMERSON, PH.D., AND FRANK A. BARILE, PH.D.[1]

The authors have developed a brief rating scale to expedite the rapid screening of emergency psychiatric patients who require hospital admission from those who are suitable for outpatient crisis intervention treatment. The interviewers used this scale to assess and score the patient rapidly on the basis of three factors: dangerousness, support system, and motivation or ability to cooperate. The authors report on and discuss the use of the scale in a preliminary study of 300 cases and in a prospective study of 122 patients who were followed for 6 months after they were evaluated. They found that those who scored below a median point on the scale required hospitalization and those who scored higher were suitable for crisis intervention as outpatients.

The decision whether or not to admit a psychiatric patient at risk for hospitalization can be accelerated by a brief rating scale which accurately predicts that decision. In psychiatric emergencies where life-threatening problems must be contained and resolved, there is a high premium on rapid assessment (4). One study (1) in a large urban hospital emergency room found that dispositional assessments for more than half the patients had to be made in a 5- to 15-minute period.

There are many retrospective analyses of factors which have affected the disposition of emergency psychiatric patients. Baxter *et al.* (1) list 23 differences between patients admitted or discharged from the emergency room. Duration of illness, previous illness, danger, ability to communicate, and personal appearance head the list. They also consider subjective factors such as the resident's liking the patient and whether the resident was a beginner or advanced in training. Flynn and Henisz (3) propose a scale based on 12 criteria, each of which is graded in intensity from 0 to 3 and weighted by a multiplier from 1 to 4. The three factors with a weight of 4 are active suicide risk, aggressive outbursts toward people, and whether the patient's condition requires the special facilities of the hospital. Four factors with a weight of 2 likewise are concerned with suicidal or assaultive potential or whether the physical or psychiatric condition requires hospitalization to initiate the treatment process. Flynn and Henisz used the scale to score 100 patients who were hospitalized and 50 who were not. Ninety-four per cent of the hospitalized patients scored below 12 while 93 per cent of those not hospitalized scored 12 or higher. Although they used the checklist only to audit charts retrospectively, they believe it could have substantial value as a preadmission screening instrument.

Warner (10) selected six criteria for hospitalization and graded each criterion numerically with respect to intensity, assigning a maximum rating to each which expressed the relative importance of that criterion in determining the need for hospitalization. The criteria, and the maximum possible rating for each, are: a) present mental status, 4; b) self-care ability, 2; c) responsible parties available, 2; d) patient's effect on environment, 3; e) danger potential, 3; and f) treatment prognosis, 2. When a group of 37 patients who had been hospitalized and 37 who had not were scored retrospectively, the former group scored 10 or more and the latter group 9 or less. Although Warner states that a rating of 10 or above or 9 or below is "currently used as the dividing line for hospitalization or non-hospitalization" (10, p. 128), he does not describe how or to what extent the scale is used as a disposition determinant.

Of the seven factors listed by Streiner *et al.* (9) as affecting the decision to admit, danger to self or others was the principal reason for admission of more than half of the group they studied. In their nonhospitalized group, the chief reasons not to admit were that symptoms did not warrant admission, there was no danger to self or others, and social supports were available. They comment that as the number of resources (social supports) increases from 0 to 3+ the percentage of those requiring hospital admission decreases from 52 to 29. Mendel and Rapport (7) see a similar decline (from 63 to 35 per cent) in the numbers of patients having to be admitted as social supports increase.

In their extensive overview of the literature on

[1] Psychiatric Institute, Westchester County Medical Center, Valhalla, New York 10595. Send reprint requests to Dr. Bengelsdorf.

The authors thank Donald M. Shapiro, D.Sc., and Kyla M. Titus of the New York Medical College for their assistance in evaluating the data.

psychiatric emergencies, Gerson and Bassuk (4) focus attention on the specific determinants of disposition. They critically review research in this area under these headings: patient demographic variables, diagnosis, dangerousness, severity of psychopathology, psychiatric history, social supports, therapist variables, and patient-therapist relationship variables. They then suggest seven factors as the basis of a new evaluative approach to a triage model for emergency psychiatric treatment. These criteria will be detailed and discussed later.

Rose *et al.* (8) complain of the paucity of studies of the criteria on which the decision to admit or not are based. Maxmen and Tucker (6) likewise address the absence of specific admission criteria and suggest a two-stage admission process in which the first step is a preadmission screening designed to gather only enough information to determine whether the patient should be admitted.

Description of Crisis Intervention Program

The Westchester County Medical Center is a major psychiatric receiving hospital. It is virtually the only hospital in the County authorized to admit patients on an emergency basis (commitment by one psychiatrist on grounds of dangerousness to self or others) and thus receives the major share of referrals of the acutely and severely psychiatrically ill. Requests for admission or for emergency psychiatric services for adult patients are routinely referred to the Mobile Psychiatric Crisis Intervention Service, staff availability permitting. A crisis team consisting of a psychiatrist and one other mental health professional assesses each case for suitability for outpatient crisis intervention treatment *vs.* the need for admission, then immediately implements that decision. Whenever possible, this assessment is carried out in the community at the site of the emergency. It is the mandate of the mobile service to procure effective outpatient treatment whenever this is safe and feasible, in preference to hospitalization.

Preliminary Study

Soon after the inauguration of the crisis intervention program, we recognized the need for a rating scale that would assist us in making the disposition decision as rapidly as possible. We sought a scale, therefore, based on the fewest criteria that would most reliably and quickly predict the decision we might come to after more extensive examination.

We examined the assessments we made in the first few months of operation, seeking the most important criteria used in making the disposition decision. Three factors emerged repeatedly: 1) the degree of dangerousness of patient to self or others; 2) the capability and willingness of the patient's family or other social support network to assist in the treatment plan; and 3) the patient's motivation and ability to cooperate in an outpatient treatment plan.

We devised a Likert-type (Appendix) rating scale, which permits the assignment of a numerical score from 1 to 5 on each of three dimensions: A) dangerousness (1 = most dangerous to self or others, 5 = least); b) support system (1 = poor or absent, 5 = excellent); and c) motivation and ability to cooperate (1 = least, 5 = most). Descriptive statements are given as examples for each of the possible scores in each area. These statements do not purport to cover every possibility but are illustrations which facilitate assignment of a numerical score. A simple sum of the three scores provides the crisis triage rating. Early trials of this Crisis Triage Rating Scale (CTRS) indicated that most of those with scores of 8 or lower were referred for admission while those with 10 or higher tended to be deemed suitable for outpatient crisis intervention treatment.

Methods

The Crisis Intervention Service Staff consists of some 30 psychiatrists, psychologists, psychiatric social workers, and psychiatric nurses. All are familiar with the scale and trained in its use. Each team of two professionals, assessing the patient together, was instructed to assign a grade of 1 to 5 in each of the three categories. The interviewers, after noting the rating, then indicated, by checking one of two lines, whether the patient had been referred for hospital admission or a plan made for brief, intensive outpatient treatment, *i.e.*, crisis intervention.

Interviewers were instructed to use the CTRS score as an indicator of suitability for crisis intervention *vs.* the need for hospitalization depending on whether the score was above or below 9. For those scoring 9 either decision could be made. Where clinical judgment disagreed with the decision predicted by the triage rating, judgment was to prevail and the clinicians were to write a brief explanation for the discrepancy.

We examined and rated 300 patients. The majority (180) were seen and evaluated away from the hospital by mobile crisis intervention teams. The remainder (120) were screened by crisis teams after arriving at the hospital but before the admission evaluation was done.

We tested for inter-rater reliability by having two interviewers (L. E. L. and R. L. E.) independently assess and rate a series of 26 patients.

Results

Predictions of the disposition decision based on CTRS scores were concordant with clinical judgment in 291 of the 300 cases (97 per cent). That is, in only nine cases was the crisis team's judgment of suitability for crisis intervention *vs.* the need for hospitalization contrary to the outcome predicted by the CTRS (Table 1).

Of the 132 scoring 8 or less, 128 were sent for admission and four were not. Of the 140 scoring 10 or higher, 135 were started in, or referred for, outpatient treatment and five were sent for admission. Half of the 28 patients who scored 9 were sent for admission and half for crisis intervention.

Table 1 breaks down the 300 cases into two groups, one seen outside and the other at the hospital. 180 patients were seen away from the hospital. Fourteen of these scored 9; of these three were admitted and 11 selected for crisis intervention. Of the remaining 166, 40 scored 8 or less; 37 of these were admitted and three were not. One hundred twenty-six scored 10 or higher; 122 of these were chosen for crisis intervention and four were admitted.

One hundred twenty patients were seen after they had been brought to the hospital. Fourteen of these scored 9; of these 11 were admitted and three were not. Of the remaining 106, 92 had scores of 8 or less; 91 were referred for admission, one was not. Fourteen scored 10 or higher; 13 of these were selected for crisis intervention and one referred for admission.

In the separate series of 26 patients rated independently by two interviewers, we calculated reliabilities using the Kappa (κ) coefficient (2). These coefficients were calculated for each dimension and for the total score. They were: A) dangerousness $\kappa = .35$, $\chi^2 = 28.611$, $df = 12$, $p < .005$; B) support $\kappa = .42$, $\chi^2 = 25.857$, $df = 6$, $p < .005$; C) motivation $\kappa = .55$, $\chi^2 = 52.599$, $df = 16$, $p < .005$; and total scale $\kappa = .42$, $\chi^2 = 72.713$, $df = 49$, $p < .02$.

Discussion

The high concordance (97 per cent) of predictions of the admission decision by CTRS scores with clinical judgment is interpreted as an indication that the CTRS is useful in two ways. In the first place, it rapidly predicts what the decision will be. In the second place, it plays an influential part in determining what that decision will be. Thus any statistical test to determine the significance of the high concordance would be flawed. The usefulness of the CTRS prediction is attested to by the finding that in only 3 per cent of cases was it necessary for clinical judgment to overrule the disposition suggested and predicted by the CTRS. In order truly to test significance it would be necessary to have a series of patients given CTRS scores by one team and to have the actual clinical decisions and dispositions carried out by a second team blind to the ratings of the first team. If sufficient staff were available this might be a worthwhile future project.

Two of the nine discordant dispositions involved patients who were intoxicated with alcohol when evaluated. One, with a score of 11, was admitted to a detoxification unit and the other, who scored 4, was threatening to jump off a roof, but did not require admission after a few hours of sobering up. In general, the Crisis Intervention Service does not get involved with cases in which drug or alcohol intoxication is the primary disorder, choosing instead referral to resources that specialize in those disorders. In addition, the CTRS has not been a useful instrument for assessing patients suffering from intoxication, where so often the clinical picture changes rapidly.

When the Crisis Intervention Service began, we hypothesized that when first contacts with patients

TABLE 1

Disposition of Patients (Preliminary Study) by CTRS Scores and Place of Evaluation

CTRS Score	Outside Hospital ($N = 180$)		At Hospital ($N = 120$)		Combined ($N = 300$)	
	No. Admitted	No. Intervened	No. Admitted	No. Intervened	No. Admitted	No. Intervened
3	0	0	8	0	8	0
4	3	0	16	1	19	1
5	10	0	27	0	37	0
6	9	0	18	0	27	0
7	8	0	10	0	18	0
8	7	3	12	0	19	3
9	3	11	11	3	14	14
10	1	18	0	2	1	20
11	2	19	0	2	2	21
12	0	31	0	4	0	35
13	0	33	0	3	0	36
14	1	13	1	0	2	13
15	0	8	0	2	0	10
Total	44	136	103	17	147	153

were made away from the hospital, we would be more successful in averting admissions than when patients were first seen after they arrived at the hospital. In the first place, there is an element of selection in choosing which cases should be seen away from the hospital. When staff is limited, cases more suitable for crisis intervention will be selected over those in which admission seems more unavoidable. Second, the *fait accompli* of a patient having been brought to the hospital has often so strongly mobilized the expectations of patients, family, and professionals, that a process that might never have been initiated is now in motion and is difficult to reverse.

In the preliminary study, comparison of patients seen outside with those seen at the hospital confirmed those expectations. Those brought to the hospital needed a score of 10 or more to be considered suitable for outpatient treatment, and 11 out of the 14 scoring 9 were admitted. In the group seen away from the hospital, 11 out of 14 scoring 9 were *not* admitted, and even among those scoring 8, three out of 10 were judged not to require admission.

The Kappa coefficients obtained on the 26 patients scored independently by two raters indicate a significant degree of reliability between raters on each of the three dimensions and on the total scores.

Prospective Study

Although the CTRS showed high concordance with clinical judgment, our preliminary series went no further than the initial disposition decision. In order to assess the usefulness of the scale as a predictor of the need for hospitalization, we designed a 6-month prospective study to determine the predictive value of the ratings in terms of the actual dispositions.

We also wanted to determine the relative weight of each of the subscales, A) dangerousness, B) support system, and C) motivation and ability to cooperate, as well as the total score, in determining which of the three categories our patients fell into, 1) not hospitalized, 2) hospitalized first day, or 3) hospitalized later.

Methods

Instructions were as before: use the rating score as an indicator except when clinical judgment dictates otherwise. The actual initial disposition was noted on the day of the first face-to-face contact and the progress of the patient recorded at the end of 1 week, 1 month, 3 months, and 6 months. We entered 160 consecutive referrals to the Crisis Intervention Service into the study.

In order to determine the relative weight of each of the subscales in determining the admission decision, we performed a stepwise discriminant analysis, which is a statistical method of determining the relative contribution of each of the independent variables (subscales) (5).

Results

Of the 160 cases referred, 38 were eliminated: 15 who were primarily cases of drug or alcohol abuse, 21 with whom we were unable to maintain contact for the 6-month period, and two who were under 18 years of age.

We followed 122 adult psychiatric patients for the full 6-month period (Table 2). 35 patients scored from 3 to 8. Of these, three were never hospitalized and 27 were admitted on the first day they were seen. Five of the eight who were not admitted when first seen, were hospitalized within 6 months. Those with low triage scores were thus admitted in 32 out of 35 cases (91 per cent).

Seventy-nine patients scored from 10 to 15. Only one of these was admitted on the day first seen; 78 (99 per cent) were deemed not to be in immediate need of hospitalization. Of the original 79 patients, 18 (23 per cent) were eventually admitted during the 6-month follow-up period.

Eight patients scored 9. Four of these were not hospitalized. Four were admitted to the hospital, one on the first day seen and three subsequently.

A stepwise discriminant analysis (Table 3) shows the relative contribution of each of the subscales and of the total scale in determining each of the three possible disposition categories.

Discussion

We arrived at the three factors chosen for the triage evaluation empirically on the basis of our early experience in making disposition decisions, but claim no originality for the criteria we selected, all of which are referred to frequently in the literature. Our CTRS, based on these three factors, can be seen as a rapid screening device whose application can constitute the first of the two-stage admission process called for by Maxmen and Tucker (6) wherein only enough information is acquired to determine whether admission is likely to be necessary.

Gerson and Bassuk (4) have identified seven criteria of dispositional significance: 1) support system, 2) dangerousness, 3) psychiatric history and current status, 4) self-care abiltiy, 5) motivation and capacity to participate in treatment, 6) requests of patient and family, and 7) medical status. Of their seven criteria the first, second, and fifth are identical with those we have chosen to use. To a considerable extent, three of their remaining four factors can be subsumed under the primary three. For example, psychiatric history and current status (No. 3) enter into the assessment

TABLE 2
Disposition of Patients (Prospective Study) by CTRS Scores and Timing of Hospitalization

CTRS Score	Not Hospitalized	Hospitalized Same Day	Hospitalized after First Day	Hospitalized within 1 Week	Hospitalized within 1 Month	Hospitalized within 3 Months	Hospitalized within 6 Months	Total Hospitalized
3	0	0	0					0
4	0	4	0					4
5	0	6	0					6
6	1	7	0					7
7	1	4	3	1	1	1		7
8	1	6	2	1	1			8
9	4	1	3	1	1	1		4
10	6	1	8	2	2	2	2	9
11	20	0	3	2		1		3
12	9	0	3	1	1		1	3
13	15	0	0					0
14	6	0	3	3				3
15	5	0	0					0
Total	68	29	25	11	6	5	3	54
Mean score	11.76 ± 1.86	6.31 ± 1.61	10.24 ± 1.98					

TABLE 3
Standardized Stepwise Discriminant Analysis Coefficients

	Not Hospitalized	Hospitalized First Day	Hospitalized Later
A. Dangerousness	.97233	.19937	.63815
B. Support system	.78936	.72337	.69173
C. Motivation	−.17680	−.19405	−.30852
Total	3.03916	1.68413	2.77420

of dangerousness and motivation. Ability to care for oneself (No. 4) is considered in evaluating the importance of the support system, *i.e.*, the less self-care a patient is capable of, the better the support system must be. The patient's desires (No. 6) are related to motivation, the family's (No. 6) to the support system. As for medical status (No. 7), urgent medical illness usually takes precedence over the need for psychiatric treatment. Chronic physical illness is not usually a determinant of disposition for psychiatric treatment. Our use of only the three categories we have chosen permits a rapid evaluation without really eliminating any factors significant to the determination of disposition.

The disposition decision appears to depend upon the interrelationship of the factors chosen. A very dangerous patient who wants to stay out of the hospital and can cooperate in doing so, and who has an effective support system to mitigate the danger, may score as high as 11 (1-5-5) and be judged suitable for nonadmission. Similarly, a patient with a low score in one of the other categories can be buoyed up by high scores in the other two areas. If a patient scores 5 in any category, *i.e.*, is not at all dangerous or has excellent support or is very highly motivated, he need average only 2 in each of the other two areas to get a total score of 9, which will be sufficient in half the cases to indicate that he might be kept out of the hospital.

This is borne out by the results of the stepwise discriminant analysis of the three subscales and the total scale (Table 3). The standardized discriminant function coefficients are of analytic importance in that, when the sign is ignored, each coefficient may be interpreted in analogous fashion to beta weights in multiple regression. Each coefficient represents the relative contribution of its associated variable (subscale) to that function (category) (5). The total scale emerges as the most discriminating among the groups for categorization purposes. In the "not hospitalized" group, the magnitude of the standardized discriminant function coefficient for the total scale was greatest, followed by subscales A) dangerousness, B) support system, and C) motivation, in that order.

In the "hospitalized first day" and "hospitalized after first day" categories, the magnitude of the coefficients for the total scales was again greatest, but the coefficients for the subscales indicate that B carries the most weight followed by A, then C. These analyses suggest the conclusions that a judgment that a patient is, above all, not dangerous, and that there is also a good support system, are the most important factors determining who will not be hospitalized. Hospitalization on the first day seen is correlated most closely with the lack of an adequate support system, while the 22 per cent of patients who are not hospitalized immediately but require admission during the course of the following 6 months are also correlated chiefly with a poor support system, followed closely by the factor of dangerousness. But clearly the weighting of the total scales for each category is much greater than any of the individual subscales in determining the hospitalization categorization.

In the prospective study, we did not expect the high concordance of crisis triage scores with clinical disposition that we had achieved in the preliminary

study (97 per cent). In the latter, we stopped following the progress of the case as soon as a rating was obtained and a disposition decision arrived at. In fact, deciding that a patient should be admitted does not always assure such an outcome; the decision not to admit a patient is often acknowledged to be a time-limited one. It may, for instance, be decided that a patient can safely be managed at home for the 1 or 2 days it will take for a bed to become available at a particular community hospital. Even when there is no anticipation of a future hospital admission of a patient selected for crisis intervention treatment, it is acknowledged that the assessment of suitability for outpatient treatment is valid only at the time it is made. We understand that when we are able to prevent an admission, it may only be for the duration of the present crisis. There is no guarantee that hospital admission will not become necessary in the future. Actually, it can be anticipated that some patients will likely require hospitalization eventually; the effect of the Crisis Intervention Service in such cases, then, may be only to delay or forestall that eventuality. In most cases, though, our goal is to avert completely or to postpone indefinitely the need for admission. Furthermore, although we operate on the assumption that outpatient treatment is preferable to hospitalization, we recognize that this is not always true. Certainly, there are cases in which the patient can easily and safely be treated out of the hospital but in which more effective care can be given in a hospital.

In the prospective study (Table 2), there were 35 patients who scored from 3 to 8, predicting the need for admission. We actually hospitalized 27 (75 per cent) of these immediately. In the 6-month follow-up period, five more were ultimately admitted, raising the total of low-scoring patients who were admitted to 32 (91 per cent). Three patients (9 per cent) in this group were not admitted at all during the 6-month period. This indicates that the CTRS slightly overpredicts the need for admission, thus serving to protect the patient at risk.

In the high scoring (10 to 15) group, only one patient had to be admitted immediately despite his score of 10, but, as anticipated, eight more were admitted during the first week, and, during each of the three subsequent follow-up periods, 1 month, 3 months, and 6 months, three more patients were admitted. Over the 6-month period, we were able to keep out of the hospital 61 of the 79 patients with high scores (77 per cent) and to delay for from 1 to 172 days the hospitalization of 17 others (22 per cent).

As in the preliminary study, dispositions of those scoring 9 were evenly divided between admission and outpatient treatment. The score of 9 is thus not useful in helping to determine disposition other than to suggest that either course might be acceptable.

We were especially concerned with the possibility of untoward outcomes of our dispositions, particularly with the risk of harm to the patients themselves or to others. No patients in our prospective study suffered self-injury or caused harm to others in the period of study. One, who scored 10 and was not hospitalized, was subsequently arrested and jailed for shoplifting and was ultimately sent by the court to a State psychiatric hospital. Another, who scored 5 and was admitted to our psychiatric ward, was found to be in the County Jail at the 3-month follow-up. There were no other arrests and no suicides, assaults, or homicides in the study period.

The limitations of the Crisis Triage Scale as we have developed and used it should be noted. We have applied it only to adults, and we have excluded those for whom the use of drugs or alcohol is a primary problem. The population we serve includes a high percentage of cases at risk for hospitalization. We operate from a County receiving hospital base where most of the adult psychiatric admissions are involuntary. Thus, we seek constantly to draw as sharp a line as possible between those who must be admitted and those who might safely be treated outside the hospital. Our scale would probably be most useful to other public psychiatric receiving facilities where similar considerations apply. In psychiatric facilities in the private sector, where very difficult or involuntary patients cannot easily be managed, or where there is less incentive for admission diversion, and where mobile crisis intervention services are not available, we would expect the dividing line to be at a higher point on the scale than ours is. Patients with scores of, for example, up to 10 or 11 might be referred to public facilities for admission, and those with 12 or higher who could possibly be kept out, will at times be deemed likely to benefit from inpatient treatment. The goals of the facility and the availability of alternative treatment services will determine how the CTRS should be used to be a useful aid in determining disposition.

References

1. Baxter, S., Chodoroff, B., and Underhill, R. Psychiatric emergencies: Dispositional determinants and the validity of the decision to admit. Am. J. Psychiatry, *124:* 1542–1548, 1968.
2. Cohen, J. A coefficient of agreement for nominal scales. Educ. Psychol. Meas., *20:* 37–46, 1960.
3. Flynn, H. R., and Henisz, J. E. Criteria for psychiatric hospitalization: Experiences with a checklist for chart review. Am. J. Psychiatry, *132:* 847–850, 1975.
4. Gerson, S., and Bassuk, E. Psychiatric emergencies: An overview. Am. J. Psychiatry, *137:* 1–11, 1980.
5. Klecka, W. R. Discriminant analysis. In Nie, N. H., Hull, C. H., Jenkins, J. G., *et al.*, Eds., *Statistical Package for the Social Sciences: SPSS.* McGraw-Hill, New York, 1975.

6. Maxmen, J. S., and Tucker, G. J. The admission process. J. Nerv. Ment. Dis., *156:* 327–340, 1973.
7. Mendel, W. M., and Rapport, S. Determinants of the decision for psychiatric hospitalization. Arch. Gen. Psychiatry, *20:* 321–328, 1969.
8. Rose, S. O., Hawkins, J., and Apodaca, L. Decision to admit. Arch. Gen. Psychiatry, *34:* 418–421, 1977.
9. Streiner, D. L., Goodman, J. T., and Woodward, C. A. Correlates of the hospitalization decision. Can. J. Public Health, *66:* 411–415, 1975.
10. Warner, S. L. Criteria for involuntary hospitalization of psychiatric patients in a public hospital. Ment. Hygiene, *45:* 122–128, 1961.

Appendix: Crisis Triage Rating Scale

Instructions: score 1 to 5 in each category using descriptive statements as guidelines.

A. Dangerousness (circle number)
   1. Expresses or hallucinates suicidal/homicidal ideas or has made serious attempt in present illness. Unpredictably impulsive/violent.
   2. Same as 1, but ideas or behavior are to some degree ego-dystonic or history of violent or impulsive behavior but no current signs.
   3. Expresses suicidal/homicidal ideas with ambivalence or has made only ineffective gestures. Questionable impulse control.
   4. Some suicidal/homicidal ideation or behavior, or history of same, but clearly wishes and is able to control behavior.
   5. No suicidal/homicidal ideation or behavior. No history of violent/impulsive behavior.

B. Support system (circle number)
   1. No family, friends, or others. Agencies cannot provide immediate support needed.
   2. Some support might be mobilized but its effectiveness will be limited.
   3. Support system potentially available but significant difficulties exist in mobilizing it.
   4. Interested family, friends, or others but some question exists of ability or willingness to help.
   5. Interested family, friends, or others able and willing to provide support needed.

C. Ability to cooperate (circle number)
   1. Unable to cooperate or actively refuses.
   2. Shows little interest in or comprehension of efforts to be made in his behalf.
   3. Passively accepts intervention maneuvers.
   4. Wants to get help but is ambivalent or motivation is not strong.
   5. Actively seeks outpatient treatment, willing and able to cooperate.

Total Score ____

Disposition

Referred for admission screening

Accepted as crisis patient